16. HIV/AIDS

Overview

Acquired immune deficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV). The disease is characterized by a weakened immune system, making the body susceptible to a number of infections and conditions, which the immune system would normally fight off.

The first cases of AIDS in the nation were diagnosed in the early 1980s, primarily in white homosexual men. In recent years, the proportion of new AIDS cases among this population group has declined, while AIDS cases among black homosexual men, heterosexual women, and injection drug users have increased. Early in the epidemic, the District of Columbia was reported to have the highest incidence of AIDS per capita in the nation. By 1987, the Centers for Disease Control and Prevention (CDC) had ranked the District of Columbia fifth among US cities (behind New York, San Francisco, Los Angeles, and Houston) for the highest number of reported AIDS cases.

As of December 31, 1998, there were 11,312 cumulative cases of AIDS in the District of Columbia. There were 11,144 cases among adults/adolescents and 167 AIDS cases among pediatrics (age 12 and under at the time of their initial diagnosis). Of the adult/adolescent cases, 5,345 (47 percent) were alive, 5,967 were deceased, 83 percent were males and 17 percent were females. Female heterosexuals went from being 2 percent of AIDS cases in 1989 to 11 percent of AIDS cases in 1998. African Americans accounted for 74 percent of the reported cases, whites accounted for 22 percent of the cases, Hispanics 3 percent, and other race/ethnicity groups 1 percent of the cases.

Residents of the District of Columbia comprised 0.24 percent of the national population, represented a disproportionate 1.6 percent of the nationally reported AIDS cases in 1998. In that same year, the rate of AIDS per 100,000 population was 189 for the District compared to 18 per 100,000 for the entire United States. This was indicative of the disproportionate impact of the epidemic in the District of Columbia.

The proportion of total AIDS cases in the District among women also is increasing. Since 1993, AIDS cases reported among women have grown at a faster rate than among men and are still rising. Adult/adolescent women with AIDS in the District of Columbia account for 21 percent (1,851) of the alive cases reported through December 31, 1998, and 25 percent (1,024) of the newly reported cases between 1995 and 1998. Women tend to be younger than men at the time of AIDS diagnosis. In 1998, a larger proportion of AIDS cases was reported among injection drug users (34 percent) than among heterosexuals or bisexuals (29 percent). Furthermore, heterosexuals with no other risk identified, accounted for 15 percent of the reported cases, and persons in other risk categories accounted for 3 percent or less.

As triple therapies and protease inhibitors become more available, there has been a decrease in reported AIDS cases. This decline in AIDS cases is due to the successful treatment of HIV-infected patients with these combination therapies which prevent or delay infected persons from developing low CD4 counts and subsequent opportunistic infections. As new and promising therapies are developed, they

are made available to residents through the AIDS Drug Assistance Program (ADAP) which is funded under Title 11 of the Ryan White Care Act.

Because of these new therapies, the number of reported AIDS cases has stabilized. AIDS cases remained at approximately the same level (about 1,000 cases reported each year) from the beginning of 1995 to the end of 1998, after a surge of reported cases in 1994 (1,362) and 1993 (1,500). The surge was attributable to the expansion of case definition in 1993. Trends in the District, as well as in the nation, show that the impact of the new medications will cause a dramatic decrease in AIDS cases reported in 1999. This is because fewer HIV-infected people advance to the AIDS-defining stages.

The Administration for HIV/AIDS (AHA), as the grantee for the entire Eligible Metropolitan Area (EMA), which includes the District of Columbia, suburban Maryland, northern Virginia, and two counties in suburban West Virginia, has actively disbursed federally allocated funds to providers of health services. AHA has aggressively initiated a series of HIV-prevention efforts in the community to reduce the incidence of HIV and AIDS, for example, mass media and social marketing campaigns, like DC Faces, to provide prevention information to District of Columbia residents. This also ensures that residents have timely access to HIV counseling and testing and sexually transmitted disease (STD) treatment services. Consequently, outreach and education activities are being targeted to specific at-risk populations, especially women, African Americans, injection drug users, Hispanics, and men who have sex with men. AHA is working with many community-based organizations and the community in its HIV/AIDS-prevention efforts and calls on all District residents to support its risk reduction initiatives.

2010 Objectives for the District

16-1. HIV/AIDS Incidence

16-1.1. Annual Incidence Rate of Diagnosed AIDS Cases among Residents

Confine the annual incidence of diagnosed AIDS cases among District residents to more than 90 per 100,000 population. (Baseline: 143 cases per 100,000 population in the District in 1998.)

16-1.2. Condom Use

Increase by 40 percent the number of condoms distributed per year to female and male residents of the District of Columbia, especially among high-risk populations. (Baseline: 167,000 distributed in 1998.)

16-1.3. Prevention Education

Facilitate the planning and delivery of training and capacity-building activities for community-based organizations involved in the direct provision of HIV prevention services to high- priority groups. (Baseline: Developmental.)

Status in 1998:

An overall decrease in the incidence and prevalence of HIV/AIDS by 2010 is expected, as a result of the

projected prevention activities, anticipated advent of new vaccines, and the increasing number of effective drugs entering the market.

16-2. HIV Mortality

Reduce mortality rate from HIV infection in the District to no more than 15 per 100,000 population.(Baseline: The mortality rate was 46 per 100,000 population in 1997)

Status in 1998:

- AIDS deaths in the District declined by 43 percent in 1997 with 243 deaths compared to 562 in 1996.
- In 1997, an overall decline was observed across all subpopulations, especially women, African Americans, and injection drug users affected by the epidemic.

16-3. HIV Treatment

16-3.1. Early Medical Intervention and Secondary Prevention fore More Adolescents and Adults Newly Diagnosed with HIV

Increase the number of adolescents and adults who, though newly diagnosed with HIV, already receive early medical intervention and secondary prevention activities in compliance with the Public Health Services Treatment Guidelines. (Baseline: 2,400 in the District in 1998.)

16-3.2. Increased Numbers of Residents Newly Diagnosed with HIV in Secondary Prevention Programs

Increase the number of newly diagnosed HIV-positive residents involved in secondary prevention programs by 1,000. (Baseline: 2,942 in the District in 1998.)

16-3.3. Increased Numbers of Dually Diagnosed Residents Enrolled in Drug Abuse Treatment Programs

Increase the number of persons dually diagnosed with substance abuse and HIV/AIDS who are enrolled in drug abuse treatment programs to 1,920. (Baseline: 96 in the District in 1998.)

Status in 1998:

- Management of HIV disease has changed significantly with the advent of new treatment therapies. People are living longer with the disease.
- Availability of new modalities for AIDS treatment, combined with effective new drugs for therapy, will lead to a reduction in the total number of individuals dying of AIDS. Also on the horizon are HIV/AIDS-related vaccines that will add a new dimension to disease prevention.
- The numbers of people enrolled in the AIDS Drug Assistance Programs, (ADAP) and of those utilizing medications, has increased substantially. From an enrollment of 1,038 clients and utilization of 537 in September of 1998.

16-4. Classroom Education

16-4.1. Increased Numbers of Elementary, Middle School, and Junior High School Children Receiving HIV and STD Prevention Education in the Classroom

Increase the proportion of schoolchildren in middle and junior high school

receiving classroom education on HIV and STDs to 30 percent. (Baseline: 24 percent of classes in middle and junior high school in 1998.)

16-4.2. Increased Numbers of Senior High School Children Receiving HIV and STD Prevention Education in the Classroom

Increase to 50 percent the proportion of students in senior high school classes receiving classroom education on HIV and STDs in the District. (43 percent in high school in 1998).

Related Program Tasks:

- Aggressively implement public and classroom education in HIV and STD.
- Implement parenthood education programs to reduce perinatal HIV transmission.
- Implement educational activities for school staff and parents.

16-5. HIV Counseling and Testing for Drug Users and Prison Inmates

Increase by 21 percent the number of residents receiving HIV antibody testing and counseling for injection drug users, in both the District at large and in District jails. (Baseline: 25,411 targeted in the District in 1998.)

Related Program Task:

- AHA, in conjunction with the Department of Corrections, has established a program to provide discharge planning, case management, and referrals to those recently released from District jails and prisons into treatment services. These services are designed to enhance utilization of treatment services following discharge.

16-6. Survival Time: Years of Healthy Life

Extend the years of healthy life of individuals infected by HIV. (Baseline: As of 1996, the interval of time between the first diagnosis of HIV infection and eventual death from AIDS was 15 to 20 years.)

Related Program Task:

- Provide additional funding to support the clinical trials program, to accommodate the expected increase in the demand for referrals from HIV/AIDS-infected residents.

Status in 1998:

- New triple therapies, coupled with the success of comprehensive prevention efforts, are delaying the progression from AIDS diagnosis to death.

16-7. Increase the Housing Services to Persons with HIV/AIDS by 200 Percent

Increase by 200 percent the number of tenant-based housing slots allotted to those with HIV/AIDS, from 130 in 2000 to 390 by 2010. (Baseline: 130 slots allotted in 2000.)

Related Program Tasks:

- Increase the percentage of the housing service budget allocated for voca-

tional rehabilitation, academic and career education opportunities, job training and placement for those with HIV/AIDS to 5 percent in 2010. (Baseline: Zero percent in 1998.)

Status in 1998:

- New drug therapies, such as protease inhibitors, have been able to slow the progression to AIDS for many of those with HIV, prolonging their lives and consequently increasing the demand for housing services.
- A Gaps Analysis was recently conducted to identify gaps in the housing service delivery system. The analysis, completed July 1, 1998, indicated that on any given day in the District, 605 individuals with HIV/AIDS, and 253 persons with HIV/AIDS in families with children are homeless. As of November of 1998, there were no emergency shelters providing an acceptable environment for persons who were immune-compromised.
- As of November 5, 1998, the average wait in the District for HIV/AIDS-specific housing slots was two years. The unmet need determined by a vendor reported that approximately 532 individuals and families are on waiting lists for the existing housing.

Comparable National 2010 Objectives

In the federal HEALTHY PEOPLE 2010 PLAN, under *Goal 13: Prevent HIV infection and its related illness and death,* comparable 2010 objectives are the following:

13-1 Reduce AIDS among adolescents and adults,

13-8 Increase the proportion of substance abuse treatment facilities that offer HIV/AIDS education, counseling, and support,

13-10 Increase the proportion of inmates in State prisons systems who receive voluntary HIV counseling and testing during incarceration,

13-13 Increase the proportion of HIV-infected adolescents and adults who receive testing, treatment, and prophylaxis consistent with current Public Health Service treatment guidelines,

13-14 Reduce deaths from HIV infection,

13-15 Extend the interval of time between an initial diagnosis of HIV infection and AIDS diagnosis in order to increase years of life of an individual infected with HIV.

13-16 Increase years of life of an HIV-infected person by extending the interval of time between an AIDS diagnosis and death.

FOCUS AREA: 16. HIV/AIDS Summary of Healthy People Objectives, Baseline Data, and 2010 Goals		
OBJECTIVE	**BASELINE**	**2010 GOAL**
16-1.1. Confine the annual incidence of diagnosed Acquired immune deficiency syndrome (AIDS) cases in the District to no more than 90 cases per 100,000 population.	143 cases per 100,000 population in 1997. (1999 Centers for Disease Control and Prevention [CDC] surveillance report.)	No more than 90 diagnosed AIDS cases per 100,000 population are detected in this year in the District.
16-1.2. Increase by 40% the number of condoms distributed per year to District residents, especially among high-risk populations.	167,000 distributed in 1998.	240,000 condoms will be distributed in this year.
16-1.3. Facilitate the planning and delivery of training and capacity-building activities for community-based organizations involved in the direct provision of human immunodeficiency virus (HIV)-prevention services for high-priority groups.	Developmental.	Planning and delivery of training and capacity-building activities are in place in the District In this year
16-2. Reduce mortality from HIV /AIDS infection among District residents to no more than 15 deaths per 100,000 population.	In 1997 in the District, the mortality rate for residents was 46 per 100,000 population.	No more than 15 deaths per 100,000 from HIV infection occur among District residents in this year.

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FOCUS AREA: 16. HIV/AIDS *(continued)* Summary of Healthy People Objectives, Baseline Data, and 2010 Goals		
OBJECTIVE	**BASELINE**	**2010 GOAL**
16-3.1. Increase the number of adolescents and adults who, although newly diagnosed with HIV, are already receiving early medical intervention and secondary prevention efforts in compliance with Public Health Services (PHS) treatment guidelines.	2,400 received such intervention and prevention efforts in the District in 1998.	Significantly more adolescents and adults newly diagnosed with HIV are already receiving early medical intervention and secondary prevention efforts in compliance with PHS treatment guidelines increase to than in 2000.
16-3.2. Increase by 1,000 the number of newly diagnosed HIV-positive residents involved in secondary prevention programs.	2,942 were involved in secondary prevention programs in the District in 1997.	The number of newly diagnosed HIV-positive residents involved in secondary prevention programs will be increased by 1,000.
16-3.3. Increase to 1,920 the number of persons dually diagnosed with HIV/AIDS and substance abuse who are enrolled in drug abuse treatment programs.	96 dually diagnosed persons were enrolled in the District in 1998.	The number of dually diagnosed persons enrolled in drug abuse treatment programs will be increased to 1,920.
16-4.1. Increase to 30% the proportion of school children in middle school or junior high school who receive classroom education on HIV and sexually transmitted diseases (STDs).	24% in middle school and junior high school classes received HIV and STDs education in the classroom in 1998.	30% of middle or junior high school classes receive classroom education on HIV and STDs.

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FOCUS AREA: 16. HIV/AIDS *(continued)* Summary of Healthy People Objectives, Baseline Data, and 2010 Goals		
OBJECTIVE	**BASELINE**	**2010 GOAL**
16-4.2. Increase the proportion of school children in high school classes who receive classroom education on HIV and STDs to 50%.	43% in high school classes received HIV and STDs education in the classroom in 1998.	50% of high school classes receive classroom education on HIV and STDs.
16-5. Increase by 21% the number of residents receiving HIV-antibody testing and counseling for injection drug users, including those in District jails and prisons.	A projected 25,400 will receive such services in the District in 2000.	31,000 residents are receiving HIV-antibody testing and counseling for injection drug users in the District, including those in District jails and prisons.
16-6. Increase the number of years of healthy life of an HIV-infected individual by extending the intervals of time between an initial diagnosis of HIV infection and AIDS diagnosis, and between that diagnosis and death.	As of 1996, the interval between first diagnosis of HIV infection and death from AIDS was 15–20 years.	Interval between HIV diagnosis and death from AIDS will be extended beyond 15–20 years.
16-7. Increase by 200% the number of tenant-based housing slots allotted to those with HIV/AIDS from 130 slots in 2000 to 390 slots.	130 tenant-based housing slots will be allotted to persons with HIV/AIDS in 2000.	390 housing slots will be allotted to persons with HIV/AIDS in this year.